Western Sierra Medical Clinic
Better Health Together

Influenza Consent Form – Pediatric (2021-2022)

www.wsmcmed.org

Patient Name: _____ DOB: _____

Please complete the checklist below so the above patient can safely receive an appropriate influenza vaccine injection.

	Yes	No	Don't Know
Has the patient been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine:_____ Date given: _____			
Does the patient have a long-term health problem with heart disease, lung disease, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., Diabetes), or anemia or another blood disorder?			
Is the patient on a long-term aspirin or aspirin-containing therapy (for example, does s/he take aspirin every day?)			
Does the patient have cancer, leukemia, HIV/Aids, or any other immune system problem, or, in the past 3 months, has taken medications that weaken the immune system such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?			
Is the patient pregnant or could become pregnant within the next month?			
Does the patient live with, or expect to have close contact with, a person whose immune system is severely compromised and who must be in protective isolation?			
Is the patient receiving antiviral medications?			
Is the patient feeling sick today?			
Has the patient had the flu vaccine before?			
Has the patient had a reaction to any vaccine in the past?			
Is the patient allergic to egg, egg products, chickens, feathers or thimerosal?			
Does the patient have any allergies? Please list:			
Has the patient ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness)?			

I have read, or have had explained to me, the applicable Vaccine Information Sheet from the Centers for Disease Control and Prevention explaining the risks and benefits of the vaccine that will be administered. I have had a chance to ask questions which were answered to my satisfaction. As the parent/guardian of the above minor patient, I hereby consent to the staff of Western Sierra Medical Clinic administering an influenza vaccine containing the strains recommended by the Centers for Disease Control and Prevention (www.cdc.gov/flu/season/faq-flu-season-2021-2022).

Parent/Guardian Signature: _____ Date: _____

The following to be completed by Western Sierra Medical Clinic

Patient Name:	**DOB:**		
Western Sierra Medical Clinic	**Date Vaccinated:**	**Injection given by:**	
Lot:	**Exp:**	**Site:**	
☐ **Private Insurance**	☐ **Medi-Cal**	☐ **Self-pay**	☐ **Other**